Health Services
LOS ANGELES COUNTY

April 5, 2006

TO: Each Supervisor

FROM: Bruce A. Chernof, M.D.
Acting Director and Chief Medical Officer

SUBJECT: **DEPARTMENT OF HEALTH SERVICES (DHS) FISCAL OUTLOOK UPDATE AND DEFICIT**

This is in response to your Board's instruction on January 24, 2006 that the Department report back with a deficit management plan in response to the budget shortfalls projected for the Department of Health Services (DHS).

In the January 13, 2006 DHS Fiscal Outlook Update, the Department committed to working with the Chief Administrative Office (CAO) to develop a balanced proposed budget for Fiscal Year (FY) 2006-07, and to begin laying the groundwork to develop approaches for addressing future fiscal year projected shortfalls. This memo includes an updated fiscal outlook showing a balanced DHS budget for FY 2006-07, and a deficit management plan developed by the Department in response to the forecasted budget shortfalls in future years.

The CAO's proposed budget for FY 2006-2007 closes the Department's forecasted budget gap and balances the budget through additional County funding and $47 million in new Federal funding through a Medi-Cal managed care rate increase. While the Department has forwarded the proposal for the Medi-Cal managed care rate increase to the State, it is dependent on Federal approval. This proposal is discussed in greater detail later in this report. Obtaining Federal approval may require a substantial and coordinated effort by the County.

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This document lays out the Department's plan to focus on addressing the $300+ million annual structural deficit facing the Department which first appears in FY 2006-2007.

To improve health through leadership, service and education

BACKGROUND ON FISCAL OUTLOOK

Like public safety-net health systems across the nation, DHS has faced a series of budget crises over the last two decades or more. Because of the chronic budget shortfalls facing the health system over this period, it appears to some observers that DHS has limped from crisis to crisis. However, during this time DHS has implemented significant reforms and restructured its care delivery system. Additionally, DHS has made great strides in measuring and improving the overall quality of healthcare it provides.

While the Department acknowledges that there are opportunities to improve resource utilization and reduce costs, our forecasted budget deficits cannot be bridged by efficiencies alone. In fact, the costs of DHS hospitals, with the exception of King/Drew, compare favorably with other benchmark hospitals in their peer group in the State. A chart comparing hospital costs per day based

on reports to the Office of Statewide Health Planning and Development (OSHPD) is included as Attachment A.

The initial 1115 Waiver Demonstration in 1995, and its extension in 2000, provided a framework to fundamentally restructure from a health system focused mainly on inpatient stays to a more balanced system with an expanded network of outpatient clinics.

The Waiver required DHS to expand services and initiate new projects to improve the efficiency and quality of services. DHS accomplishments under the Waiver include:

- Ambulatory Care – The provision of eleven million primary care visits for low-income, uninsured patients through the PPP program;
- Clinical Resource Management – Inpatient clinical pathways and targeted disease management programs were developed and implemented to improve efficiency and patient outcomes;
- Administrative Reforms – A simplified eligibility determination process for receiving reduced-cost care at county outpatient facilities through creation of the Outpatient Reduced-cost Simplified Application, or ORSA;
- Data Collection – A centralized data collection process, which has improved department-wide planning and management; and
- Workforce Development Program – A partnership was developed between DHS and the Service Employees International Union (SEIU) Local 660 that provides opportunities for DHS employees represented by SEIU to receive additional job-related training and education.

However, even with reform and the other accomplishments under the Waiver, the phasing down of funding under the Waiver and its completion on June 30, 2005 has left the Department with a structural deficit of approximately $300 million annually. This amount approximates the average inflation adjusted annual loss of Federal revenue when the Waiver expired.

FISCAL OUTLOOK UPDATE

Attachment B is an update to the DHS Fiscal Outlook from our last cut-off date of January 10, 2006. Since DHS is providing this update concurrent with the CAO's presentation of its FY 2006-2007 Proposed Budget, the Summary of Changes schedule begins by showing those adjustments to DHS's January 10 update necessary to reconcile to the CAO's FY 2006-2007 Proposed Budget. At this point, the CAO's Proposed Budget shows a cumulative revised year-end balance in the DHS designation fund of $5.5 million, after funding FY 2006-2007 DHS operations.

The DHS schedule then continues on the second page of Attachment B to add potential developments beyond the CAO's Proposed Budget cut-off date, through our updated cut-off date for the DHS Fiscal Outlook of March 24, 2006. These developments result in a $98.6 million shortfall for FY 2006-2007, which is then addressed by a series of proposed deficit management actions. These actions should be sufficient to more than address the $98.6 million shortfall, leaving a projected cumulative balance in the DHS designation fund at the end of FY 06-07 of $56.5 million. They are discussed in the following pages of this report, as well as the redevelopment of the DHS strategic plan over the next six months. This redevelopment will be aimed at addressing the remaining cumulative projected shortfall of $555.2 million through FY 2009-2010, should all of the proposed deficit management plans yield the estimated benefits shown on the schedule.

DEFICIT MANAGEMENT PLAN

Although the projections show a balanced budget based on the CAO's proposed budget for FY 2006-07, the Department views this time as crucial to begin addressing the shortfalls that are projected beginning in the following year, FY 2007-08. Therefore, the Department will be implementing a number of cost-saving proposals this year that will result in immediate and on-going savings. Many of these initiatives are not new, and are grounded in the principles laid out in the Department's last strategic plan, developed in 2002. These initiatives center around transforming our five hospitals into a single unified health system through the use of shared practices, technology and resources. The Department believes that these "system-ness" initiatives offer the best chance of cost savings without reductions in services or quality.

As part of this effort, the Department plans to spend the next several months developing and implementing improved clinical practices such as increased case management for patients with chronic conditions. While these programs will require investment up front, they will provide cost savings over the long run and improve patient care.

These actions combined with potential new revenue opportunities should substantially reduce the forecasted deficits facing the Department and are discussed in greater detail below. Over the next several months, the Department will also update its Strategic Plan based on the changes to the environment in which it operates, including the new Medi-Cal Hospital Financing Waiver and the settlement agreements of the Harris and Rodde cases. These efforts will be part of the Department's broader effort over the next several months to revise and implement key aspects of the Department's strategic plan.

Implementation of Efficiencies and Cost Reductions

Nurse Registry Utilization

The statewide nursing shortage and the implementation of mandated nurse-staffing ratios has resulted in increased use of registry nurses throughout the healthcare system. However, the use of temporary registry nurses in some DHS hospitals is extraordinarily high. With the hiring of a DHS Chief Nursing Officer and the development of a Nursing Strategic Plan, the Department has developed a timetable for implementation of specific steps to increase recruitment and retention of permanent nursing professionals. The Department's goal is to reduce utilization of registry Registered Nurses (RNs) and Certified Nursing Attendants (CNAs) by a 5% reduction in both FY 2006-2007 and FY 2007- 2008 and a 7.5% reduction in FY 2008-2009. This will be achieved by hiring permanent RNs and CNAs through the implementation of initiatives in the Nursing Strategic Plan, including the creation of additional CNA items, Human Resource process improvements focused on shortening the hiring process, and the creation of an internal DHS nursing registry. Success at achieving this target is dependent on flexibility from the CAO to facilitate hiring additional CNAs and implementing the Nursing Strategic Plan. The expected cost savings is approximately $17.8 million through FY 2009-2010.

Ancillary Services

Pharmaceutical expenditures will be reduced through refinement and enforcement of the DHS Formulary. By designating some drugs as preferred and eliminating others, prescribing can be directed to the least expensive alternative when two or more drugs have equivalent clinical

effectiveness. This also enhances purchasing power in negotiating prices for pharmaceuticals. Preliminary analysis indicates that there are savings potentials in several therapeutic categories. Additionally, the Department is renegotiating its pharmaceutical supply contracts. This renegotiation is projected to save $1.6 million annually.

Laboratory expenses will be reduced through standardization of equipment and consolidation of certain testing where rapid turn-around time is not needed. Chemistry and immunology analyzers represent the greatest opportunity for savings from standardization; other laboratory equipment is also being evaluated for standardization potential. Laboratory standardization is estimated to save $2.2 million through FY 2009-2010.

Expenses related to equipment and supplies for special medical procedures will also be reduced through standardization. For example, standardization of pacemakers, stents, and catheters used in cardiac laboratories increases purchasing power, lowering per-item costs for these items. Potential savings opportunities exist in cardiology, radiology, gastroenterology, and intensive care. Savings through standardization of equipment and supplies is estimated at $2.8 million annually.

Potential additional savings from initiatives in pharmacy, laboratory, and standardization of medical equipment and supplies is pending further analysis.

Medi-Cal Inpatient Treatment Authorization Request Denials

In January 2005, DHS established a facility-wide Patient Flow Task Force with a charter to analyze how DHS patients flow through our system of care, identify barriers to efficient and effective patient flow, and to make recommendations to the Department.

While the Medi-Cal Inpatient Treatment Authorization Requests (TAR) process is complex and subject to interpretation by DHS and the State's Medi-Cal Field Office (MFO) personnel, one of the areas identified by the Group for improvement is the number of Medi-Cal TARs denied that are within the control of the Department. Inpatient days denied by the State's MFO that DHS categorizes as possible controllable represent a financial savings to the Department due to a combination of increased Medi-Cal revenue and cost reductions. While these days may be labeled as possible controllable, they often are not. For example, if a Medi-Cal patient were to spend an extra day in the hospital because the test they needed was unavailable due to mechanical breakdown of a piece of diagnostic equipment, that day may be denied and labeled as possible controllable. However, some of the denials are within our control and can be avoided through improved management of resources and patient flow.

To reduce Medi-Cal inpatient TAR denials, DHS is working with:

- the State to review the TAR process by participating in an audit of TAR dispositions submitted by all contract and non-contract hospitals, the results of this review may change the TAR process, resulting in reducing Medi-Cal inpatient TAR denials which the Department believes are excessive;

- the Hospital Association of Southern California to address Los Angeles-area provider hospital TAR issues, identifying solutions to common issues, etc.; and

- the DHS hospital CEOs to establish Medi-Cal inpatient TAR day denial reduction targets for denials related to delays in requesting or providing services, documentation for continued stay, and justification for admission.

The Patient Flow Task Force has proposed to reduce by at least 10%, the number of inpatient days denied based on specific denial codes. A 10% reduction in these days in the next fiscal year would provide an estimated $3.4 million in savings. Additional recommendations from the Patient Flow Task Force are currently being evaluated.

Mental Health Services

The Department provides mental health services to patients through Psychiatric Emergency Services (PES) and inpatient psychiatric services at four DHS hospitals. In addition, outpatient mental health services are provided at LAC+USC Medical Center. The costs associated with these services continue to present challenges to the Department. While the Department of Mental Health (DMH) provided an additional $2 million in FY 2004-05 and $5.486 million in FY 2005-06 to DHS to support these mental health services, this funding still does not come close to covering the costs incurred by DHS. Over the next several months, the Department will work with DMH and the CAO to address this funding deficit issue which will drive the development of the memorandum of understanding (MOU).

The current DHS allocation from DMH for psychiatric services only covers funding for inpatient days. There is no allocation for patients who are treated in the PES. The Department's unreimbursed cost for PES patients in FY 2004-05 was over $44 million. If DHS is to continue operating psychiatric emergency services, a reimbursement mechanism must be negotiated with DMH.

- In addition to the non-reimbursement for PES patients, another funding issue is related to patients no longer needing acute psychiatric inpatient care, but staying in inpatient beds for weeks on end due to a lack of available placement options. Currently about 30%-50% of the 136 operating DHS psychiatric inpatient beds are occupied by patients who no longer require acute psychiatric care and therefore DHS is not reimbursed at the full Medi-Cal rate. This results in a funding gap of $2.6 million for patients with Medi-Cal. This issue must be addressed in the MOU that is currently being negotiated.

- With the exception of LAC+USC Medical Center, all mental health outpatient clinic services provided at our hospitals are currently operated by DMH. Only LAC+USC Medical Center is operating a mental health outpatient clinic. If LAC+USC's outpatient service is transferred to DMH, there is a potential cost savings of $1.1 million annually.

Operational Efficiencies

Included in the Department's forecast is $20.9 million in savings through efficiencies at King/Drew Medical Center. The Department believes that these savings are achievable but will be difficult given the regulatory challenges that the facility has faced and their rapid pace of change. Additional potential savings are being evaluated in the areas of improvement in the Department's return to work program, purchasing, contracts for equipment maintenance, and billing systems.

Revenue Strategies

November Tobacco Tax Initiative

At present, a voter initiative is in circulation for the November 2006 ballot which would increase taxes by $2.60 per pack of cigarettes and allocate the proceeds to a variety of health-related programs including, among other things, increased funding for public and private hospital emergency services, and expanded children's health insurance coverage. According to the Legislative Analyst's Office, the proposed measure is estimated to raise $1.2 billion in 2006-07, reflecting a partial year implementation of the tax, and about $2.1 billion in 2007-08, the first full year of the tax. Proponents of the initiative have estimated higher annual proceeds of $2.27 billion, of which $828 million would be allocated for hospital-based emergency services under the initiative's formula, approximately $96 million could benefit DHS hospitals.

Hospital Waiver Health Coverage Initiative

Under the recent Medi-Cal hospital financing reform waiver, California has the potential to access up to $180 million annually in Federal funds for three years (FY 2007-08 through FY 2009-2010) subject to the creation of a health coverage program for uninsured patients. The existence of the $180 million is attributable to the spending history of the County's waiver, which was incorporated into the State's recent waiver. Although DHS' direct access to this funding ended with the expiration of the County's waiver on June 30, 2005, it may be possible to recapture a portion of this funding.

Under the waiver terms and conditions, the State is required to submit a plan for approval to the federal government by September 1, 2006, in order to access these funds effective September 1, 2007. In January 2006, the State initiated a stakeholder process to gain input on how to configure this program, and has indicated the desire to secure legislation authorizing the health coverage initiative during the current legislative session. DHS is working with other public hospitals and the Disproportionate Share Hospitals (DSH) Task Force to craft a proposal that would allow safety net hospitals to retain/control these funds under the Medi-Cal Redesign "hospital" waiver. The Department estimates that Los Angeles County may capture $50 million annually of this funding beginning in FY 2007-2008 through FY 2009-2010.

Managed Care Rate Proposal

Since 2003, DHS has been working with the State to develop a supplemental financing mechanism through LA Care that would benefit the County health system. Under the proposed arrangement, The State would increase the Medi-Cal payments to LA Care in an amount that is agreed to by the parties and that is consistent with the federal requirements of actuarial soundness. The non-federal share of this mechanism would be funded through intergovernmental transfers (IGTs) from the County to the State. We understand that the State's actuarial estimates would support an increase of at least $100 million annually, including the federal and non-federal share.

The additional payments to LA Care would be passed through to DHS in the form of supplemental payments to the Community Health Plan (CHP). After applying the amounts received to cover the uncompensated costs of services rendered to CHP's Medi-Cal enrollees, the County would agree to retain the balance (including the nonfederal share funded by the IGT) in DHS to be used to support the County's system of safety net providers.

This funding mechanism could be available in any fiscal year in which the County is prepared to contribute the IGT and in which the State can demonstrate to the federal Centers for Medicare and Medicaid Services (CMS) that the additional payments to LA Care are within the federal payment limit. However, it is not clear how the State's anticipated expansion of Medi-Cal managed care would affect the County's ability to use this mechanism in the future.

LA Care has expressed its support for the proposal if it continues to be structured in such a way as to not result in any losses for LA Care. In addition, the State is supportive of the County's proposal and came forward with the concept. Federal approval of the proposed funding mechanism and the annual payment amounts will be necessary. The State has obtained federal approval to implement a similar mechanism in another county. However, that proposal was for a one-time supplemental payment and on a substantially smaller financial scale. Therefore, gaining Federal approval will take a concerted and organized effort by the County and will be a top priority for the Department.

Hospital Financing Waiver

Under the State's five-year Medi-Cal Redesign federal waiver and its implementing State legislation, several events will likely converge in year 3 (FY 2007-08) to cause a potential reopening of the waiver. They are:

1) Expiration of the 60%/40% public/private hospital sharing agreement of monies beyond DSH hospital baseline reimbursement levels at the end of year two;
2) Reimbursement for the public hospital costs of the uninsured from the Safety Net Care Pool (SNCP) must be counted in determining hospital-specific DSH caps beginning in FY 2007-08, further constraining the level of Medi-Cal reimbursement public DSH hospitals can receive; and
3) Public hospital bottom lines will likely have deteriorated substantially by year 3, aggravated by fixed and flat annual amounts from the two largest sources of public hospital reimbursement under Medi-Cal Redesign, the SNCP and the DSH pool, over the five-year life of the waiver.

While these developments may be somewhat cushioned in the event of a $180 million per year coverage proposal favorable to the public DSH hospitals, they are likely to be significant enough to result in a situation that could create an opportunity to head off otherwise unacceptable levels of public hospital downsizing and closures.

(The Department's financial forecast already anticipates the full value of the Medi-Cal Redesign federal waiver through FY 2009-2010, excluding Los Angeles County's potential share of the $180 million per year. This amount is tied to managed care during FYs 2005-06 and 2006-07 and to an uninsured coverage initiative in FYs 2007-08, 2008-09 and 2009-10.)

Outlook and Environment

In 2002, the Department began to implement its strategic and operational plan to preserve the most critical pieces of the safety net in response to daunting deficits that were forecast. When the voters of Los Angeles County approved Measure B (a parcel tax to support trauma, emergency, and bioterrorism preparedness) in November 2002 and additional one-time federal Medicaid funds were made available to the Department in February 2003, the more draconian reductions in the health system, including the closure of one or more major medical centers, were pulled back.

The court has recently approved settlements in both the Harris and Rodde cases which challenged the County's proposed closure of 100 beds at LAC+USC Medical Center and the closure or transfer of Rancho Los Amigos National Rehabilitation Center (RLANRC) to another operator. In addition to other requirements in the settlement, the County agreed to continue to operate RLANRC at a reduced size for three years or until a takeover of the facility is effectuated that preserves core rehabilitation services and access for patients, and to reduce beds at LAC+USC at specified intervals as reductions in length of stay the facility are achieved.

As we move forward, if we are unable to make needed changes, managing the deficit will become increasingly challenging. As previously reported to you, the funding distribution under the State's Medi-Cal hospital financing waiver has only been determined for this and in part for the next fiscal year. The Department's forecast assumes that the current distribution formula stays in place for the remaining three years. The Department, and the hospital industry as a whole, has concerns about the viability of the hospital waiver as a sufficient funding stream to maintain operations in years three through five because of the lack of growth in funding under the Waiver and the uncertainty of the distribution formula. The approach taken by the Department to generate the estimates related to the Hospital Financing Waiver is summarized in Attachment C.

It is essential that the Department have a contingency plan in place if the cost-savings and revenue proposals discussed in this document do not close the projected budget gap. However, the Department recommends that the focus remain on identifying and implementing revenue sources and reforms to manage the fiscal outlook today. A cut list at this point would unnecessarily destabilize the facilities and programs impacted. Therefore, the Department is not planning to develop a list of major service reductions and facility closures at this time unless they are deemed necessary when we have a clearer sense of our shortfalls in light of the above plans. A contingency plan will be developed in the context of the Department's overall strategic plan as outlined below.

Strategic Plan

In its June 19, 2002 memo to your Board, the Department clearly articulated a forward looking vision: ***"An integrated and coordinated system of care for medically indigent and Medi-Cal patients with a balanced system of inpatient, outpatient and emergency services."*** This memo laid out five redesign elements: 1) Aligning DHS services and patient populations; 2) Defining the DHS benefits package; 3) Creating a County Health Benefit Program; 4) Improving use of information technology; and 5) Instituting performance management. This vision and these redesign goals are sound and the Department needs to move forward with their implementation.

The Department is committed to a thoughtful review and redevelopment of our strategic plan over the next two quarters. This will allow time for a comprehensive review of current data, re-evaluation of implementation strategies and events that have transpired over the last few years, and collaborative work with key stakeholders.

The Department's strategic plan will specifically address each of the following five areas that remain central to the full realization of the Department's vision and the redesign goals:

1) Implement "System-ness" initiatives, including consolidation of some specialty programs and the implementation of department-wide standardized unit staffing and productivity metrics;

2) Reduce barriers between community-based primary care and hospital-based specialty care, including the addition of ambulatory diagnostic centers and promotion of more community-based specialty care;
3) Implement a Medical Home Case Management and Health Benefit Program for chronically ill high-utilizers to help reduce utilization and improve quality of care;
4) Complete implementation of the Unique Patient Identification number for patients seen in any DHS facility; and
5) Complete and implement a Medical Benefits Package that clearly identifies which services are provided or excluded.

The Department is committed to reducing the looming structural deficit through specific and tangible actions while also continuing the transformation of DHS into a more effective and efficient healthcare delivery system.

While these strategic initiatives are important to the continued transformation of the Department into a more effective and efficient delivery system, the Department is committed to taking specific, tangible steps this fiscal year to reduce the looming structural deficit.

CONCLUSION

The Department remains committed to the vision of an integrated and coordinated system of care for medically indigent and Medi-Cal patients with a balanced system of inpatient, outpatient and emergency services. To that end, the Department commits to the following actions:

1) Work with the DSH Task Force to aggressively pursue maximum reimbursement to public hospitals through the Hospital Financing Waiver and other potential revenue sources;
2) Implement the internal efficiencies and cost reductions outlined in this document; and
3) Conduct a robust strategic planning process that includes stakeholder input by November 30, 2006.

In addition, the Department requests that your Board support the November Tobacco Tax Initiative, which could result in up to $96 million in annual revenue for DHS.

The above approach begins to address the significant budget shortfalls facing our health system. While none of these efforts alone will solve the DHS deficit, the Department is optimistic that this multi-faceted approach to managing the deficit is a rational start to reducing the most immediate shortfalls facing our health system.

If you have any questions or need additional information, please let me know.

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Attachments

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

SUMMARY OF CHANGES IN THE DHS FISCAL OUTLOOK

JANUARY 10, 2006 THROUGH MARCH 24, 2006

	Fiscal Year / Columns / $ In Millions					
	05-06 / (1)	06-07 / (2)	07-08 / (3)	08-09 / (4)	09-10 / (5)	Total / (6)
(1) Revised Estimated Cumulative Year-End Fund Balance / (Shortfall) - January 10, 2006	$ 240.1	$ (65.9)	$ (391.5)	$ (781.4)	$(1,145.8)	$(1,145.8)
(2) Increase nursing costs to enable the Department to meet the AB 394 nursing ratios per the CAO-Proposed Budget for April 18, 2006 and extend through FY 09-10.	$ -	$ (82.4)	$ (108.3)	$ (110.3)	$ (112.4)	$ (413.4)
(3) Add the proposed Managed Care Rate Supplement included in the CAO-Proposed Budget for April 18, 2006.	-	94.0	94.0	94.0	94.0	376.0
(4) Adjust CBRC revenue estimates on January 17, 2006 to include audit results for FY 02-03 and extend through FY 09-10.	45.1 (A)	19.6	20.2	20.8	21.4	127.1
(5) CAO adjust employee benefits per the CAO-Proposed Budget for April 18, 2006. Amounts extended through FY 09-10 by DHS and improve due to a reduced rate of growth in retiree health insurance	-	(20.4)	(14.7)	(10.5)	(5.3)	(50.9)
(6) CAO adjust vehicle license fee estimates for FY's 05-06 through 09-10 based on estimates received on March 7, 2006.	3.2	9.1	10.4	11.8	13.1	47.6
(7) CAO adjust debt service costs per the CAO-Proposed Budget for April 18, 2006. Does not reflect changes related to the Tobacco Securitization.	-	(10.6)	(10.6)	(10.6)	(10.6)	(42.4)
(8) Adjust HSA costs, primarily for overhead (B) and additional positions for contract monitoring; clinical affairs and affiliations; audit and compliance; and health data & planning, per the CAO-Proposed Budget for April 18, 2006.	-	(9.8)	(9.8)	(9.8)	(9.8)	(39.2)
(9) Increase billings from Other County Departments based on the CAO-Proposed Budget for April 18, 2006. Amount primarily due to increased Office of Public Safety costs and ISD Utilities costs.	-	(9.2)	(9.5)	(9.8)	(10.1)	(38.6)
(10) CAO exclude requested increase in LAC+USC Order Management/Document Imaging and Transition costs for the replacement project per the CAO-Proposed Budget for April 18, 2006.	-	31.9	-	-	-	31.9
(11) Expand orthopedic services at OVMC per CAO-Proposed Budget for April 18, 2006.	-	(5.0)	(7.0)	(7.0)	(7.0)	(26.0)
(12) CAO reverse salary COLA increase per CAO-Proposed Budget for April 18, 2006.	-	25.3	-	-	-	25.3
(13) Efficiency savings at K/DMC.	-	(20.9)	-	-	-	(20.9)
(14) CAO increase intrafund transfers from Probation to JCHS per the CAO-Proposed Budget for April 18, 2006.	-	5.0	5.0	5.0	5.0	20.0
(15) Reduce CHIP-Hospital estimates per the Governor's Proposed Budget for FY 06-07 released in January 2006.	-	(4.5)	(4.5)	(4.5)	(4.5)	(18.0)
(16) CAO adjust capital projects per the CAO-Proposed Budget for April 18, 2006.	-	11.8	-	-	-	11.8
(17) Purchase equipment for K/DMC per Board approval on January 31, 2006.	(6.7)	-	-	-	-	(6.7)
(18) CAO adjust DHS request for a 12% CPI increase in the rates paid to Public-Private Partners to 3% per CAO-Proposed Budget for April 18, 2006.	-	(1.2)	(1.2)	(1.2)	(1.2)	(4.8)
(19) Other minor ongoing changes. (C)	-	(2.9)	(5.6)	(5.1)	(4.7)	(18.3)
(20) Forecast improvement/(reduction) roll-forward	-	41.6 (D)	71.4 (D)	29.8 (D)	(7.4) (D)	-
(21) Revised Estimated Cumulative Year-End Fund Balance / (Shortfall) - Per CAO-Proposed Budget	$ 281.7	$ 5.5	$ (361.7)	$ (788.8)	$(1,185.3)	$(1,185.3)

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Potential Developments Subsequent to CAO-Proposed Budget Cutoff						
(22) Potential increase medical school agreement costs per estimates developed on March 10, 2006.	$ (10.4)	$ (12.7)	$ (15.0)	$ (17.4)	$ (20.3)	$ (75.8)
(23) Include Distressed Hospital Fund revenue per request sent to CMAC on March 24, 2006.	7.0	7.0	7.0	7.0	7.0	35.0
(24) Restore and adjust LAC+USC Order Management/Document Imaging and Transition costs per facility estimates received in March 2006.	6.4	(30.5)	(1.4)	(2.6)	(3.1)	(31.2)
(25) Amortize "unidentified budget surplus" added by the CAO for November 2005 through January 2006.	(27.0)	-	-	-	-	(27.0)
(26) Restore CAO reduced salary COLA per DHS Budget Request on January 30, 2006.	-	(25.3)	-	-	-	(25.3)
(27) Purchase CT scanners for H/UCLA, K/DMC, RLA, OVMC, and HDHS per estimates developed on March 24, 2006. FY's 07-08 through 09-10 reflect maintenance cost savings.	-	(28.3) (E)	0.5	1.5	1.2	(25.1)
(28) Include previously postponed efficiency savings at K/DMC.	-	20.9	-	-	-	20.9
(29) Restore CAO reduced rate increase for Public-Private Partners per DHS Budget Request on January 30, 2006.	-	(4.7)	(4.7)	(4.7)	(4.7)	(18.8)
(30) Adjust salary COLA per estimates developed on March 24, 2006.	-	(3.1)	(3.4)	(3.7)	(4.0)	(14.2)
(31) Restore phase two of the Board approved roofing projects for FY 06-07 (phase three is already included in the FY 07-08 estimates).	-	(3.6)	-	-	-	(3.6)
(32) Reduce Harris/Rodde enabler costs at LAC+USC per facility estimates received in March 2006.	2.2	-	-	-	-	2.2
(33) Other minor ongoing changes. (F)	(2.8)	0.8	-	(0.6)	(1.8)	(4.4)
(34) Forecast Improvement/(reduction) roll-forward	-	(24.6) (D)	(104.1) (D)	(121.1) (D)	(141.6) (D)	-
(35) **Adjusted Revised Estimated Cumulative Year-End Fund Balance / (Shortfall) - March 24, 2006** (G)	$ 257.1	$ (98.6)	$ (482.8)	$ (930.4)	$(1,352.6)	$(1,352.6)
Proposed Deficit Management Actions						
(36) Net Savings from Conversion of Nursing Registries to County Employees (H)	$ -	$ 1.0	$ 3.0	$ 5.5	$ 8.3	$ 17.8
(37) Ancillary Services [Pharmacy ($1.6M), Laboratory ($0.5M), Standardized Medical Supplies ($2.8)]	-	4.9	4.9	4.9	4.9	19.6
(38) 10% Reduction in Medi-Cal Inpatient TAR Denials	-	3.4	3.4	3.4	3.4	13.6
(39) Mental Health Services (I)	-	50.8	52.5	54.2	55.9	213.4
(40) November 2006 Tobacco Tax Initiative	-	48.0	96.0	96.0	96.0	336.0
(41) Hospital Waiver Health Coverage	-	-	50.0	50.0	50.0	150.0
(42) Additional County Contribution	-	47.0	-	-	-	47.0
(43) Forecast improvement/(reduction) roll-forward	-	- (D)	155.1 (D)	364.9 (D)	578.9 (D)	-
(44) **Proposed Revised Estimated Cumulative Year-End Fund Balance / (Shortfall) - March 24, 2006** (G)	$ 257.1	$ 56.5	$ (117.9)	$ (351.5)	$ (555.2)	$ (555.2)

Notes

(A) FY 05-06 reflects changes for FY's 01-02 through 05-06.

(B) This adjustment restores HSA overhead to the correct level, since Rancho's ADC reduction from 191 to 147 beds per the Harris/Rodde settlement reflected a reduced HSA overhead.

(C) Primary amounts for FY's 06-07 through 09-10 include increased rents & leases costs, increased S&S CPI costs, and increased interest expense costs.

(D) These amounts represent the cumulative change in the forecast from the prior fiscal year. For example, the $41.6 million in FY 06-07 is $281.7 million - $240.1 million from FY 05-06.

(E) Funding for the estimated purchase cost of $28.3 may come from the Tobacco Settlement Designation.

(F) Primary amounts include changes in facility estimates received in March 2006 for the current year, increased Medicare revenue for FY's 06-07 through 09-10, and increased S&S CPI costs for FY's 06-07 through 09-10.

(G) - Assumes CBRC/FQHC will be extended for each year beyond FY 04-05. CBRC extension for LA County's outpatient and clinic care was included in the FY 05-06 Adopted State Budget. A Medi-Cal State Plan Amendment to extend the program is currently pending CMS approval.
- Includes additional Medi-Cal Redesign funding of $72.7M, $92.1M, $106.4M, $112.7M, and $119.1M for FY's 05-06 through 09-10, respectively, for a total benefit of $503.0M over five years.
- Includes efficiency savings for K/DMC of $20.9M, $29.5M, $30.8M, and $32.1M for FY's 06-07 through 09-10 respectively

(H) Reflects the conversion of nursing registries to County employees at a rate of 5% in FY 06-07 (beginning in January 2007), 5% in FY 07-08, 7.5% in FY 08-09 and 7.5% in FY 09-10.

(I) Includes psych emergency services ($47.0M), admin days paid as acute days ($2.8M), and the outpatient clinic at LAC+USC ($1.0M). Amounts are for FY 06-07 and increase by a 3% COLA in FY's 07-08 through 09-10

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

HOSPITAL COST PER DAY

PER OSHPD[1] ANNUAL DISCLOSURE REPORT

FISCAL YEAR 2003-2004

FACILITY #	HOSPITAL NAME	(A) TOTAL OPERATING EXPENSES	(B) TOTAL INPATIENT[3] OPERATING EXPENSES	(C) TOTAL OUTPATIENT OPERATING EXPENSES	(D) TOTAL PHYSICIAN PROFESSIONAL COMPONENT	(E) (B)X(M)/(D) INPATIENT[4] PHYSICIAN PROFESSIONAL COMPONENT	(F) (C)X(M)/(D) OUTPATIENT PHYSICIAN PROFESSIONAL COMPONENT	(G) (B)+(E) ADJUSTED INPATIENT EXPENSES	(H) TOTAL PATIENT DAYS (Excl Nursery)	(I) (G)/(H) COST PER DAY	(J) ANNUAL OSHPD TOTAL (Incl Nursery) DISCHARGES	(K) (G)/(J) OSHPD COST PER DISCHARGE
	L.A. COUNTY OPERATED MAJOR TEACHING HOSPS. [2]	$1,751,362,478	$1,029,021,913	$722,340,565	$305,382,569	$139,178,424	$166,204,145	$889,843,489	$518,256	$1,717	83,179	$10,698
	OTHER CA COMPARABLE HOSPITALS:											
106010848	ALAMEDA COUNTY MEDICAL CENTER	$323,933,479	$249,650,336	$74,283,143	$30,698,325	$23,658,707	$7,039,618	$225,991,629	111,697	$2,023	13,114	$17,233
106364231	ARROWHEAD REGIONAL MEDICAL CENTER	324,271,790	213,399,969	110,871,821	29,170,144	19,196,575	9,973,569	194,203,394	109,596	1,772	20,979	9,257
106190110	BROTMAN MEDICAL CENTER	119,372,035	105,981,980	13,390,055	675,371	599,614	75,757	105,382,366	78,641	1,340	9,281	11,355
106190125	CALIFORNIA HOSPITAL MEDICAL CENTER	165,208,957	122,914,408	42,294,549	7,163,170	5,329,353	1,833,817	117,585,055	69,549	1,691	13,472	8,728
106190555	CEDARS-SINAI MEDICAL CENTER	1,183,104,391	905,589,408	277,514,983	82,418,779	63,086,211	19,332,568	842,503,197	284,959	2,957	46,445	18,140
106100717	COMMUNITY MEDICAL CENTER - FRESNO	446,982,979	300,553,545	146,429,434	25,895,560	17,412,301	8,483,259	283,141,244	171,934	1,647	31,773	8,911
106190400	HUNTINGTON MEMORIAL HOSPITAL	325,954,480	267,342,325	58,612,155	9,158,669	7,511,785	1,646,884	259,630,540	138,019	1,883	25,571	10,161
106150738	KERN MEDICAL CENTER	176,173,231	138,622,769	37,550,462	27,497,056	21,636,193	5,860,863	116,986,576	55,896	2,093	13,555	8,631
106361246	LOMA LINDA UNIVERSITY MEDICAL CENTER	672,792,588	506,282,814	166,509,774	49,319,254	37,113,207	12,206,047	469,169,607	189,544	2,475	30,511	15,377
106190525	LONG BEACH MEMORIAL MEDICAL CENTER	328,125,915	256,765,852	71,360,063	1,923,340	1,505,056	418,284	255,260,796	128,751	1,983	24,648	10,356
106381154	UCSF MEDICAL CENTER	1,049,094,414	703,701,584	345,392,830	195,974,392	131,453,841	64,520,551	572,247,743	162,044	3,531	25,560	22,388
106334487	RIVERSIDE COUNTY REGIONAL MED CTR	247,908,598	180,347,897	67,560,701	25,058,253	18,229,312	6,828,941	162,118,585	86,001	1,885	18,562	8,734
106380939	SAN FRANCISCO GENERAL HOSP MED CTR	407,828,267	297,911,140	109,917,127	27,676,752	20,217,365	7,459,387	277,693,775	143,122	1,940	16,849	16,481
106430883	SANTA CLARA VALLEY MEDICAL CENTER	610,010,982	392,382,096	217,628,886	85,383,709	54,922,025	30,461,684	337,460,071	122,135	2,763	23,470	14,378
106370744	SCRIPPS MERCY HOSPITAL	260,867,332	206,719,751	54,147,581	8,544,320	6,770,797	1,773,523	199,948,954	100,700	1,986	21,214	9,425
106190053	ST. MARY MEDICAL CENTER	165,567,678	123,988,977	41,578,701	4,774,603	3,575,566	1,199,037	120,413,411	79,268	1,519	11,913	10,108
106380965	ST. MARY'S MEDICAL CENTER-SAN FRANCISCO	144,146,735	108,212,276	35,934,459	2,927,223	2,197,493	729,730	106,014,783	49,195	2,155	7,447	14,236
106430905	STANFORD UNIVERSITY HOSPITAL	1,041,160,945	634,229,377	406,931,568	130,784	79,668	51,116	634,149,709	119,881	5,290	21,250	29,842
106190796	UCLA MC & NEUROPSYCHIATRIC HOSPITAL	885,666,271	613,391,042	272,275,229	21,956,158	15,206,304	6,749,854	598,184,738	198,438	3,014	28,840	20,741
106370782	UNIVERSITY OF CALIF-SAN DIEGO MED CTR	529,185,589	362,515,279	166,670,310	16,128,495	11,048,725	5,079,770	351,466,554	125,123	2,809	21,790	16,130
106341006	UNIVERSITY OF CALIFORNIA DAVIS MED CTR	843,938,324	637,713,061	206,225,263	36,322,276	27,446,543	8,875,733	610,266,516	146,013	4,180	26,627	22,919
106301279	UNIVERSITY OF CALIFORNIA IRVINE MED CTR	414,064,164	329,823,394	84,240,770	15,253,779	12,150,419	3,103,360	317,672,975	104,853	3,030	17,819	17,828
106560481	VENTURA COUNTY MEDICAL CENTER	191,630,194	110,430,300	81,199,894	20,223,065	11,653,900	8,569,165	98,776,400	49,172	2,009	10,065	9,814
106190878	WHITE MEMORIAL MEDICAL CENTER	193,336,165	142,312,341	51,023,824	11,521,393	8,480,754	3,040,639	133,831,587	96,923	1,381	17,171	7,794
	TOTAL - OTHER CA COMPARABLE HOSPITALS	$11,050,325,503	$7,910,781,921	$3,139,543,582	$735,794,870	$520,481,714	$215,313,156	$7,390,300,207	2,921,454	$2,530	497,926	$14,842
	TOTAL - U.C. HOSPITALS	$3,721,948,762	$2,647,144,360	$1,074,804,402	$285,635,100	$197,305,832	$88,329,268	$2,449,838,528	$736,471	$3,326	120,636	$20,308
	STATEWIDE AVERAGE	$34,227,479,952	$25,809,539,988	$8,417,939,964	$933,769,257	$704,117,131	$229,652,126	25,105,422,857	15,925,627	$1,576 [5]	N/A	N/A

(1) Office of Statewide Health Planning and Development

(2) The LA County major teaching hospitals are LAC+USC Medical Center, Harbor/UCLA Medical Center, Martin Luther King, Jr/Drew Medical Center, and Olive View Medical Center

(3) For LA County Hospitals, the Inpatient / Outpatient split is based on the FY 2003-04 Medi-Cal Cost Report

(4) For LA County Hospitals the Physician Inpatient / Outpatient split is based on the FY 2002-03 Cost Model

(5) The Statewide Average includes hospitals that have an Average Daily Census that is greater than 150. The Statewide Average is based on the hospitals' fiscal year that ended in Calendar Year 2003.

ATTACHMENT C

Estimate of Medi-Cal Redesign of LAC-DHS

Recent legislation (SB 1100) will dramatically restructure inpatient Medi-Cal payments to the California's safety net DSH hospitals (SNDH) under the State's new 1115 waiver. According to a data analysis distributed by the State on 8/29/05, a total of $433.2M of the new $766M Safety New Care Pool (SNCP) under the waiver will be required to meet "hold harmless" baselines of SNDHs in FY 05-06. These baselines are actual FY 04-05 inpatient Medi-Cal revenue levels earned by SNDHs, including fee-for-service, DSH, SB 1255 and GME components.

Further, the SNCP is diminished by $180M annually unless the State meets specific managed care milestones in FY's 05-06 and 06-07 and establishes a new coverage program(s) in the last three years of the waiver. Since it is unclear as to whether the State will meet these requirements and, even if so, unclear as to the adverse impact on SNDHs workload of mandatory managed care enrollment of the aged, blind and disabled Medi-Cal eligibles (representing 40% of LAC-DHS' Medi-Cal patients), and the creation of a new coverage program(s), we have excluded the availability of the $180M from our financial estimates at this time. Further, the value of the $180M will likely be diminished in FYs 07-08 through 09-10, as the Waiver requires that these amounts, and all other SNCP funds be counted as $1.75, for each dollar received, against hospital OBRA '93 DSH caps.

Based on the State's 8/29/05 analysis, after deducting the baseline and $180M amounts, and applying the equity adjustments and formulas in SB 1100 to the residual SNCP amount, it is roughly estimated that LAC-DHS will receive about $55M in "stabilization" funds beyond its "hold harmless" baseline in FY 05-06. This amount is contingent on a pending CMS interpretation of allowable CPEs, which will impact both DSH and non-DSH revenue levels.

Accordingly, we have adjusted the DHS Fiscal Outlook to reflect the total ($841.0M) of the "hold harmless" baseline and "stabilization" funds for FY 05-06. The previous amount, adjusted for Harris/Rodde, was $768.3M, per the last (June 20, 2005) Fiscal Outlook update to the Board. For future fiscal years, we have anticipated 3% growth in the Medi-Cal inpatient component, except for the undocumented alien component, which must be funded by DSH funds for both Medi-Cal eligibles and the uninsured. The statewide totals for DSH and the SNCP do not grow over the five-year waiver term. Similar to DSH, we have held constant SNCP funding which covers 50% of the allowable inpatient uninsured cost.

(Even though the post-equity adjustment, public-private sharing percentages of 60%/40% expire after two years and the public hospital 70% baseline/30% donor percentages expire after one year, these formulas are used to project amounts through all five years, since the probability of their continuance is likely as good as any alternatives.)